

Attributional style in a case of Cotard delusion

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Abstract

Young and colleagues (e.g. Young, A. W., & Leafhead, K. M. (1996). *Betwixt life and death: case studies of the Cotard delusion*. In P. W. Halligan & J. C. Marshall (Eds.), *Method in madness: Case studies in cognitive neuropsychiatry*. Mahway, NJ: Lawrence Erlbaum Associates.) have suggested that cases of the Cotard delusion (the belief that one is *dead*) result when a particular perceptual anomaly (caused by a disruption to the affective component of visual recognition) occurs in the context of an internalising attributional style. This hypothesis has not previously been tested directly. We report here an investigation of attributional style in a 24-year-old woman with Cotard delusion (“LU”). LU’s attributional style (and that of ten healthy control participants) was assessed using the Internal, Personal and Situational Attributions Questionnaire (Kinderman, P., & Bentall, R. P. (1996). A new measure of causal locus: the internal, personal and situational attributions questionnaire. *Personality and Individual Differences*, 20(2), 261–264.). LU showed a significantly greater proportion of internalising attributions than the control group, both overall and for negative events specifically. The results obtained thus support an association of Cotard delusion with an internalising attributional style, and are therefore consistent with the account of Young and colleagues. The potential brain basis of Cotard delusion is discussed.

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1. Introduction

Few pathologies of the self are as profound and striking as those reported in cases of Cotard syndrome, which can involve the belief that one is *dead*. The assertions of some patients with this delusion come close to violating the famous Cartesian dictum *cogito ergo sum*. Descartes explored the limits of radical scepticism and concluded that whereas one could certainly doubt the evidence of one’s senses, it was not possible to doubt one’s existence. Yet some Cotard patients maintain that they are dead or that they do not exist (Young & Leafhead, 1996).

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The classic reports of this condition were published by the psychiatrist Jules Cotard (e.g. Cotard, 1882), who described a clinical state that he termed *délire des négations*. The French eponym *délire de Cotard* was later adopted, and translated into English as Cotard's syndrome (Berrios & Luque, 1995a). Although this latter designation is often identified with the belief that one is dead, Cotard himself did not regard that belief as an essential defining feature of the condition he described (Berrios & Luque, 1995b; Young & Leafhead, 1996). Young and Leafhead's analysis of Cotard's (1882) cases revealed a series of commonly occurring features and symptoms, including self-deprecatory delusions, suicidal ideation,¹ feelings of guilt, and denial of body parts. Young and Leafhead's subsequent comparison of three patients with the belief that they had in fact died revealed a consistent combination of additional symptoms including depressed mood, abnormal feelings, depersonalisation and derealisation, and evidence of face-processing impairments. More exotic concurrent symptoms have been reported elsewhere, including hydrophobia (Nejad, 2002) and lycanthropy (Nejad & Toofani, 2005). The issue of whether the Cotard phenomenon is best conceptualised as a psychiatric symptom or a discrete syndrome is yet to be resolved (Silva, Leong, Weinstock, & Gonzales, 2000; Young & Leafhead, 1996). For present purposes we shall equate the term "Cotard delusion" with the belief that one is dead.

According to Gardner-Thorpe and Pearn (2004), the Cotard delusion usually presents in the context of schizophrenia or bipolar disorder, although it may also occur subsequent to organic insult. Temporo-parietal lesions of the non-dominant hemisphere are particularly implicated in cases of Cotard delusion associated with cerebral trauma. A patient described by Young, Robertson, Hellowell, de Pauw, and Pentland (1992) provides an example of this presentation. For months following a motorcycle accident, the patient was convinced that he was dead. Computerised tomography (CT) scans showed contusions affecting temporo-parietal areas of the right hemisphere as well as some bilateral damage to the frontal lobe.

A variety of authors have suggested that the most comprehensive explanation of monothematic delusions such as the Cotard delusion will implicate contributing factors at two levels—the experiential and the inferential (see for e.g. Davies, Coltheart, Langdon, & Breen, 2001; Ellis & Young, 1990; McKay, Langdon, & Coltheart, 2005b; Wright, Young, & Hellowell, 1993; Young & de Pauw, 2002; Young, Leafhead, & Szulecka, 1994; c.f. Gerrans, 2000, 2002). Such two-factor explanations incorporate an *empiricist* perspective on delusion formation (Campbell, 2001), in that they implicate unusual perceptual experiences (caused by a spectrum of neuropsychological abnormalities) as a first factor in delusion formation (see also Maher, 1992, 1999; Maher & Ross, 1984). Anomalous perceptual experiences are not thought to be sufficient for the development of delusions, however, because there exist individuals with such experiences who do not develop delusory beliefs about them (Langdon & Coltheart, 2000). Two-factor models thus invoke an additional explanatory factor or set of factors, to account for how perceptual anomalies lead to the adoption of delusional beliefs.

Young and colleagues (e.g. Wright et al., 1993; Young, 2000; Young & Leafhead, 1996; Young et al., 1994) have proposed that the Cotard delusion results from a similar anomalous perceptual experience to that putatively involved in the Capgras delusion (see Ellis, Whitley, & Luaute, 1994). Patients with the Capgras delusion believe that a loved one has been replaced by a physically identical impostor. Two independent studies have demonstrated that Capgras patients fail to show the normal pattern of autonomic discrimination (as indexed by skin-conductance response) between familiar and unfamiliar faces (Ellis, Young, Quayle, & de Pauw, 1997; Hirstein & Ramachandran, 1997). Whereas control participants showed significantly greater skin-conductance responses to familiar faces, for Capgras patients familiar and unfamiliar faces engendered skin-conductance responses of equivalent magnitude.

On the basis of such results, Capgras patients are thought to have damage to neural pathways underpinning the emotional component of face recognition (Ellis & Young, 1990; Langdon & Coltheart, 2000; Stone & Young, 1997). The ensuing discordance between experiences of the way someone "looks" and the way they

¹ Readers may rightly wonder at the paradox inherent in a person entertaining thoughts of suicide while simultaneously believing that they are dead. Such paradoxes are not uncommon where delusions are concerned (see, for example, Breen, Caine, Coltheart, Hendy, & Roberts, 2000; Brett-Jones, Garety, & Hemsley, 1987), and in fact their existence constitutes a key objection to what is known as the "doxastic conception" of delusions, i.e. the idea that delusions are beliefs. The fact that deluded individuals often seem unconcerned by manifest contradictions between their delusions and their other beliefs (Bayne & Pacherie, 2005) seems at variance with the idea that our beliefs are integrated in a "web of belief" (Quine & Ullian, 1970). Some commentators (e.g. Currie & Jureidini, 2001) have therefore argued that delusions are not actually beliefs at all.

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